

Patient Health Questionnaire

Name: _____ Date: _____

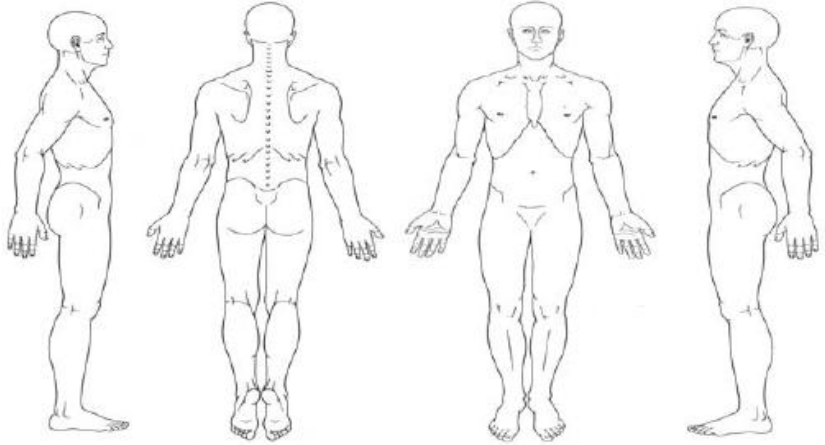
1. Describe your symptoms _____

2. Severity: ① Mild (annoyance, No impairment) ② Slight (mild impairment) ③ Moderate (impairment) ④ Severe (Incapacitated)

3. How often do you experience your symptoms?

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



4. What describes the nature of your symptoms?

- ① Sharp / stabbing ④ Shooting ⑦ Stiffness
- ② Dull ache ⑤ Burning ⑧ Numb / Tingling
- ③ Throbbing ⑥ Grabbing ⑨ Other: _____
- ⑩ Radiates to: _____

5. How your symptoms changing?

- ① Getting Better ② Not Changing ③ Getting Worse

6. Indicate the average intensity of your symptoms:

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

7. Do you have radiating pain (Arm / Leg)? ① No ② Yes: How far down does it radiate?: _____

a. If YES, the degree of radiating pain is: ① Getting Better ② Not Changing ③ Getting Worse

8. a. What helps your pain: _____ b. What aggravates your pain: _____

9a. How much has pain interfered with your Normal work (including both work outside the home, and housework) ① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

b. How much of the time has it interfered with your social activities? ① All of the time ② Most ③ Some ④ A little ⑤ None of the time

c. Overall how much do your symptoms affect your ability to perform DAILY ACTIVITIES?

- ① Not At all
- ② Mild, forgotten with activity
- ③ Moderate, interferes with activity
- ④ Limiting, prevents full activity
- ⑤ Intense, preoccupied with seeking relief
- ⑥ Severe, no activity possible

10. Affect Sleeping? ① N ② Y*: OCC / FREQ / ALWAYS b. Woken by Pain? ① N ② Y* c. Wake up Stiff? ① N ② Y

DO NOT COMPLETE # 11 & # 12 IF YOU HAVE NOT BEEN GETTING RECENT TREATMENT FOR THIS COMPLAINT

11. What are you ABLE to do (easier / longer) now than you were prior to starting treatment?

- ① Sit ② Stand ③ Walk ④ Sleep ⑤ Bend ⑥ Lift ⑦ Push/Pull ⑧ Work Activities ⑨ Household Activities ⑩ Daily self care

12. Is treatment helping? ① Not at all ② A little bit ③ Quite a bit ④ Very much

TREATMENT EFFECT: () N/A – New Episode / Flare-up

(DOCTOR ONLY)

Compliance: Attended ___ / ___ Visits

Mood and affectivity: improved deteriorated unchanged

Symptomatology: decreased increased unchanged

Range of motion: increased decreased unchanged

Strength: increased decreased unchanged

Body mechanics: improved worsened unchanged

Activity tolerance: increased decreased unchanged

RECOMMENDATIONS:

- Continue (Initiate) therapy for _____ weeks of care at a frequency of _____ times per week. Treatment to include:
- Spinal manipulation, McKenzie exercise / self-treatment protocols, Manual therapy techniques including myofascial release
- Adjunctive physiotherapeutic modalities ADL / Body mechanics / back care Therapeutic activities / exercises Home exercise program

GOALS:

- ↑ Mood and affectivity
- ↑ Range of motion
- ↑ Strength
- ↓ Symptomatology to ___/10 (with _____ % activity)
- ↓ Tenderness / tightness at least one grade
- ↑ ↑ activity tolerance by _____ %